Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN8307 | A. BUILDING: _____ B. WING _____ | 05/08/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMORELAND CARE & REHAB CTR | 1559 NEW HIGHWAY 52 WESTMORELAND, TN 37186 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>The licensure survey was completed on 5/8/19 at Westmoreland Care and Rehab Center. No deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 5/24/19